



## Testimony

Before the Subcommittee on Health, Committee on Ways  
and Means, House of Representatives

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# HCFA MANAGEMENT

## Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century

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# HCFA Management: Agency Faces Multiple Challenges in Managing Its Transition to the 21st Century

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Health Care Financing Administration's (HCFA) ability to meet its new and growing responsibilities. HCFA pays for health care coverage for nearly a quarter of the population. Two of the programs HCFA administers cost federal and state taxpayers about \$370 billion in fiscal year 1998—\$193 billion for Medicare and \$177 billion for Medicaid—and represent an ever growing proportion of the federal budget—currently about 18 percent. Because of the size and complexity of its programs, we have been reviewing HCFA's operations since the agency was created more than 20 years ago. Over the years, we have reported on problems in HCFA's management that weakened the fiscal integrity of these programs—leading to increased monetary loss from fraud, abuse, and erroneous payments. We have also reported on management problems that have led to poor-quality care provided to vulnerable beneficiaries. In 1990, we developed a list of agencies and programs that were “high risk” because of their vulnerability to waste, fraud, abuse, and mismanagement. We included Medicare on our original list, and it remains on the list to this day.

The long-term financial condition of Medicare is now one of the nation's most pressing problems. Recent legislation gave HCFA substantial new authorities and responsibilities for reforming Medicare in order to extend the solvency of Medicare's Hospital Insurance Trust Fund beyond 2008. This legislation also established the Bipartisan Commission on the Future of Medicare to develop more long-term solutions for further ensuring Medicare's integrity and solvency. Because of your concern about HCFA's preparedness to implement these new authorities and administer its programs, you asked us to review HCFA's management capacity and to testify before this Subcommittee last January. You asked us to report today on our updated assessment of HCFA's progress—focusing on the agency's ability to meet its increasing workload in the short term. Specifically, you asked us to review HCFA's progress in (1) addressing its most immediate priorities and (2) strengthening its internal management to effectively discharge its major implementation and oversight responsibilities.

We relied on our substantial body of past and ongoing work to assess HCFA's performance in meeting its current responsibilities.<sup>1</sup> We supplemented this work by interviewing 28 agency managers and officials, including the Administrator and Deputy Administrator. In addition, we

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<sup>1</sup>See Related GAO Products at the end of this statement.

conducted small focus groups attended by 46 senior and midlevel managers and 20 staff, and reviewed agency documents.

In summary, HCFA is facing an unprecedented set of challenges. The Balanced Budget Act of 1997 (BBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) were designed, with considerable input from the administration, to strengthen HCFA's ability to prevent fraud and abuse and constrain spending growth in the Medicare program. These laws added substantial new authorities and programmatic responsibilities to HCFA's ongoing management of Medicare and Medicaid. In response to these mandates and program responsibilities, HCFA's accomplishments have been impressive. However, measured against the magnitude of challenges it faces, HCFA's progress seems more modest. The immediacy and resource demands associated with meeting the Year 2000 computer system challenges—coupled with HCFA's late start in addressing them—have put a tremendous burden on the agency this past year and have affected the timing and quality of its work on many other projects. For example, it has delayed needed systems modernization and computer changes that implement new payment systems intended to slow program cost growth. It has also slowed efforts to improve the oversight of ongoing operations, such as financial management and Medicare fee-for-service claims administration, which desperately need attention. Even where HCFA has made progress—such as in implementing a number of the mandated HIPAA and BBA requirements—we believe that more work, and many refinements, are still needed.

HCFA must meet these challenges with an aging workforce. In fact, almost one quarter of its staff—most with managerial and technical experience—will be eligible to retire in the next 5 years. HCFA has taken a number of steps internally to capitalize on its staff's strengths to deal with a rapidly changing health care marketplace and growing responsibilities. For example, HCFA has developed a strategic plan that better articulates its future direction, has progressed in its customer-focused reorganization by moving staff to their new organizational units, and has hired more staff with needed skills. On the other hand, in focus groups we conducted, HCFA managers and staff discussed issues that continue to hamper effective agency operations. For example, HCFA's reorganization slowed the agency's decision-making process so that even travel funds were not allocated until well into the middle of the fiscal year. Managers also stated that the performance and awards systems neither motivate staff nor hold staff accountable for achieving program results.

To further strengthen HCFA's ability to effectively manage its employees and programs, the administration has proposed new authorities for contracting and new flexibility in hiring in the President's budget for fiscal year 2000. It also proposes new mechanisms to enhance agency accountability, with biannual reports to the Congress and an advisory board to help the agency streamline internal and program management. HCFA senior officials have taken concrete steps to improve agency management this year but will need to maintain the momentum over the next several years to overcome the agency's current and future challenges. This will be especially difficult in an agency that for years has been plagued by external pressures and management problems.

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## Background

HCFA, an agency within the Department of Health and Human Services (HHS), is responsible for administering much of the federal government's multibillion-dollar investment in health care—primarily the Medicare and Medicaid programs. Rapid increases in Medicare program costs, coupled with increasing concern about fraud and abuse in the program, led the Congress to enact legislation—HIPAA and the BBA—to strengthen Medicare. HIPAA established the Medicare Integrity Program, which ensures increased funding for Medicare program safeguard efforts and authorizes HCFA to hire specialized antifraud contractors. The BBA made the most significant changes to Medicare in decades, designed to reduce the growth of Medicare spending. The law requires HCFA to implement new payment methodologies, expand managed care options, and strengthen program integrity activities. At the same time, these laws also added entirely new responsibilities—such as oversight of private health insurance and implementation of a new state children's health insurance program—to HCFA's historic mission to administer Medicare and Medicaid.

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than \$193 billion. Most of these beneficiaries receive health care on a fee-for-service basis, in which providers are reimbursed for each covered service they deliver to beneficiaries. HCFA contracts with about 60 insurance companies to process the high volume of fee-for-service claims—numbering about 900 million in fiscal year 1997—submitted by about a million health care providers for payment. Medicare's managed care program, the other principal component, covers the growing number of beneficiaries who have chosen to enroll in prepaid health plans, where a single monthly payment covers any needed services. About 6.8 million people—about

17 percent of all Medicare beneficiaries—were enrolled in more than 450 managed care plans as of December 1, 1998.

Medicaid, a \$177 billion federal and state grant-in-aid entitlement program administered by states, finances health care for about 36 million low-income families and blind, disabled, and elderly people. At the state level, Medicaid operates as a health insurance program covering acute-care services for most recipients, financing long-term medical care and social services for elderly and disabled people, and funding programs for people with developmental disabilities and mental illnesses. In addition, the BBA created the state-operated Children's Health Insurance Program, which provides federal grants to states to provide basic health insurance coverage for low-income, uninsured children. Through this program, states have a choice of either expanding their Medicaid programs or developing a separate program to insure children.

Under HIPAA, HCFA also has a completely new responsibility for ensuring that private health insurance plans comply with federal standards. In five states that did not pass legislation conforming to key provisions of HIPAA, HCFA has direct responsibility for enforcing HIPAA standards for individual and group insurance plans. In addition, HIPAA, along with the BBA, provides HCFA more opportunities to improve its fraud and abuse identification and prevention programs in Medicare.

HCFA had about 4,100 staff as of October 1998. About 65 percent were located in the central office and the remainder worked in the agency's 10 regional offices. In addition to its workforce, HCFA oversees Medicare claims administration contractors who employed an estimated 22,000 people in fiscal year 1997.

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## **HCFA Has Made Some Progress Addressing Its Highest Priorities, but Many Problems Remain**

Last year, we told you that substantial program growth and greater responsibilities appeared to be outstripping HCFA's capacity to manage its existing workload. Today, the message is a more complicated one. HCFA has made great strides in addressing many of its immediate priorities—including readying critical computer systems for the year 2000 and implementing many provisions of HIPAA and the BBA. But the number and complexity of the BBA's requirements and the urgency of systems changes, coupled with a backlog of decades-old problems associated with HCFA's routine operations, make it clear that much more needs to be accomplished.

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## **HCFA Made a Concerted Effort on Y2K, but Critical Tasks Are Incomplete**

Over the past year, HCFA has made a concerted effort to deal with its most pressing priority—the Year 2000 computer systems problem—commonly referred to as Y2K.<sup>2</sup> If uncorrected, Y2K problems could cause computer systems that run HCFA's programs to shut down or malfunction, resulting in serious disruptions to payments to Medicare providers and services to Medicare beneficiaries. Addressing Y2K is a formidable task for HCFA, because the Medicare program uses 6 standard claims processing systems, about 60 private contractors, and financial institutions nationwide to process about 900 million Medicare claims each year for about 1 million hospitals, physicians, and medical equipment suppliers.

In September 1998, we reported that time was running out for HCFA to modify Medicare systems to handle Y2K.<sup>3</sup> HCFA was severely behind schedule in repairing and testing its systems and in developing contingency plans to handle system failures. Until 1997, HCFA was attempting to develop the Medicare Transaction System—which would be Y2K compliant—to replace its existing Medicare claims processing systems. But the project was halted because of design problems and cost overruns. This left HCFA with multiple, noncompliant Medicare claims processing systems that needed modernization. Compounding this difficult task was HCFA's failure to adequately direct and monitor its Y2K project. We recommended changes to better manage its Y2K efforts, and HCFA agreed to implement our recommendations as soon as possible.

HCFA recently reported to HHS that as of December 31, 1998, it had completed renovating 5 of the 6 standard systems used by its contractors to pay claims and all 25 of its mission-critical internal systems. We are now monitoring HCFA's progress in implementing the recommendations in our September 1998 report, and we are reviewing the agency's progress in addressing the critical areas of Y2K testing and business continuity and contingency planning. We will testify on these issues to the Congress in the next few weeks. Furthermore, although HCFA is not directly responsible for state Medicaid enrollment and payment systems, agency officials said they are concerned that some state systems may fail. To help prevent this, the agency has begun to work with states on their Y2K problems.

HCFA's progress on the Y2K front is tempered by one unfortunate reality: some of the systems HCFA is expending so much energy and resources to

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<sup>2</sup>This problem stems from the use in many computer systems of a two-digit dating system for indicating the year. With this abbreviated format, the year 2000 is indistinguishable from 1900.

<sup>3</sup>Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy (GAO/AIMD-98-284, Sept. 28, 1998).

modify to achieve Y2K compliance are obsolete and will need to be replaced soon after the year 2000. Y2K presented an immediate problem with an inflexible end point, which has forced HCFA to shelve its efforts to consolidate its Medicare claims processing systems and modernize other systems. After the termination of the Medicare Transaction System, HCFA decided to consolidate the number of systems that pay claims to reduce systems maintenance costs and streamline efforts to implement required systems changes. But systems consolidation could not go forward while HCFA and its contractors were renovating and testing their systems for Y2K readiness. As a result, it is spending millions to renovate certain systems for Y2K readiness that it plans to stop using soon after 2000.

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### **HCFA Has Made Some Progress but Is Still Struggling With HIPAA and BBA Implementation**

HCFA has completed many major tasks this past year and has implemented significant portions of HIPAA and the BBA, but progress remains slow. For example, HCFA has taken steps to allocate HIPAA funding and to implement authorities to combat waste and abuse in the Medicare program. HIPAA provided additional funds for HCFA's Medicare claims processing contractors to use to detect fraudulent and abusive billing practices. The claims administration contractors use these funds to hire and retain staff knowledgeable in conducting provider audits, claims reviews, and payment data analyses, among other activities. HCFA promptly issued the contractors' fiscal year 1999 budget allocations, unlike the situation in fiscal year 1998, when HCFA did not provide this funding to the contractors until a third of the year had passed.

As part of HIPAA, the Congress also gave HCFA the authority to contract with specialists to perform payment safeguard activities. HCFA is now reviewing the submissions it received in response to its September 1998 solicitation for bids to become a program safeguard contractor. Such a contract could be awarded by May 1999, but the scope will be limited and will not provide many of the benefits initially envisioned from using a specialty contractor.

As part of its work on BBA-mandated Medicare+Choice,<sup>4</sup> HCFA issued interim final regulations for health maintenance organizations and other types of managed care organizations (for example, preferred provider organizations and provider-sponsored organizations) to participate and

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<sup>4</sup>Medicare+Choice widens beneficiary and health plan participation in Medicare managed care by (1) guaranteeing plans a minimum payment level, intended to encourage plans to locate in areas they had previously not served; (2) expanding the types of plans eligible to contract with Medicare to include—in addition to health maintenance organizations—preferred provider organizations and provider-sponsored organizations; and (3) informing beneficiaries of the plan choices in their area through a national information campaign.



took several steps toward implementing the new National Medicare Education Program last year. The regulations, published in June 1998, represented a massive undertaking accomplished within a very short time period. In rushing to reach the deadline, however, some of the provisions were developed without full consideration of their impact on managed care organizations. For example, the regulations required that managed care plans assess the health status of all new Medicare members within 90 days of enrollment, but this requirement would include existing plan members for whom the plan may already have comprehensive information. Similarly, the regulations require each managed care organization's chief executive officer to certify that the encounter data provided to HCFA are 100-percent accurate. To managed care plans, such a standard seems unreasonable because these data are generated from many sources not directly under their control, including contracting physicians, hospitals, and other providers. In addition, managed care plans are concerned that other requirements cannot realistically be accomplished in the required time frames, may be duplicative of existing accreditation and reporting requirements, and could create disincentives to work on more difficult quality improvement projects. HCFA has agreed to reconsider a number of items and is planning to change the standard for data accuracy so that plans' chief executive officers will certify to the best of their knowledge that the data provided to HCFA are accurate.

For the new National Medicare Education Program, HCFA established an eight-point plan for educating beneficiaries about their new managed care options; implemented an Internet site for providing comparative managed care plan information; and has begun phasing in its toll-free call center and its mail-out of a revised Medicare handbook to beneficiaries in five states, which foreshadowed the nationwide mail campaign planned for this fall. The effort to produce Medicare handbooks was more complicated than the agency originally expected. Of the 15 comparative handbooks mailed to beneficiaries in different geographic areas, 12 were inaccurate because HCFA published them before managed care plans finalized their Medicare participation decisions. The Congress' efforts to encourage the growth of Medicare managed care could be thwarted if plans refuse to participate and if beneficiaries are confused, instead of enlightened, about their many health care choices.

HCFA officials acknowledge they were slow to realize that the complexity and magnitude of the Y2K problem would stall implementation of key BBA requirements. The BBA mandated the design and implementation of new payment methods called prospective payment systems (PPS), which pay

providers—regardless of their costs—fixed, predetermined amounts that vary according to patient need. To meet BBA targets, HCFA has to design and implement four PPS systems:

- a skilled nursing facility (SNF) PPS by July 1, 1998;
- a home health agency PPS by October 1, 1999, which was delayed by later legislation until October 1, 2000;
- a hospital outpatient PPS by calendar year 1999; and
- an inpatient rehabilitation PPS by fiscal year 2001.

The SNF PPS was implemented on July 1, 1998. However, to prevent additional complications during system renovation and testing for Y2K, the agency has missed deadlines to make systems changes needed for beginning the hospital outpatient and home health agency prospective payment systems. These delays could affect both budgetary savings and Medicare beneficiaries themselves. The Congressional Budget Office had estimated that new payment methods for home health and outpatient services would save Medicare about \$23 billion between fiscal years 1998 and 2002. In addition, the hospital outpatient PPS would have reduced the amounts elderly patients pay for such services. HHS estimated that between January 1999 and April 2000, senior citizens will have to pay an extra \$570 million in higher copayments over what they would have paid if the hospital outpatient PPS had been implemented on time. While many Medicare beneficiaries have some sort of third-party coverage for costs that Medicare does not cover—referred to as “Medigap” policies—they are likely to be indirectly affected because premiums for Medigap policies are increasing in line with rising Medicare costs.

Although HCFA officials were tracking both BBA and Y2K implementation, top agency officials did not inform the Congress until July 1998 that the agency would be delayed in instituting the new payment methods. HCFA officials attributed their late awareness of this problem to communications breakdowns at three levels. First, they believe operations and policy staff at headquarters responsible for designing the program changes were not consulting with each other and with others who were responsible for implementing them in the field. Second, they stated that top agency officials did not immediately find out what lower-level HCFA managers knew—how long it would take to implement complex BBA changes and how that could complicate Y2K testing of the systems. Finally, officials believe that there was inadequate consultation with Medicare contractors responsible for making the actual programming changes to their systems.

While some parts of the BBA implementation were put on hold, HCFA moved quickly to implement a new SNF PPS.<sup>5</sup> However, we believe that the SNF PPS has design flaws, and coupled with a lack of adequate planned oversight, this may diminish the anticipated reduction in Medicare costs that prospective payment was supposed to create. Savings depend on developing an appropriate daily payment (per diem) rate to reflect patients' needs. The new daily payment rate is based on the average daily cost of providing all Medicare-covered skilled nursing services, adjusted to take into account the patient's condition and expected care needs. We are concerned that the new SNF PPS' design preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services, since the amounts paid still depend heavily on the number of therapy and other services patients receive. Furthermore, HCFA has not planned sufficient oversight to prevent fraud and abuse. For SNFs, a facility's own assessment of its patients will determine whether a patient is eligible for Medicare coverage and how much will be paid. When Texas implemented a similar payment method for Medicaid, its on-site reviewers found that nursing homes' assessments were often inflated. Despite Texas' experience, HCFA does not currently have plans to monitor facilities' assessments to ensure they are appropriate and accurate. Nor has it ensured that the Medicare contractors—who pay the facilities' claims—will have timely information on patients to determine whether the rate to be paid is appropriate.

The last major BBA implementation challenge we want to highlight is the Children's Health Insurance Program—the largest health care investment in children since Medicaid was created in 1965. Although states are given broad flexibility in tailoring programs to meet their own circumstances, HCFA is responsible for approving each state's plan, providing technical assistance to the states, and ensuring that programs meet statutory requirements designed to guarantee meaningful health coverage. HCFA has initiated (1) a comprehensive effort with the states, private companies, advocacy organizations, the Health Resources and Services Administration, and others to promote this initiative and (2) an outreach effort to find those children who are eligible for health insurance under the Children's Health Insurance Program or Medicaid but are not enrolled. Since passage of the act, HCFA has approved 46 state plans, after providing extensive guidance and interim instructions to states. We are currently

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<sup>5</sup>The prior payment method reimbursed providers on the basis of their costs, with capital costs and ancillary services virtually unlimited. Because providing more services generally triggered higher payments, facilities had no incentive to provide only necessary services or to improve efficiency. Prospective payment is intended to slow spending growth by paying providers fixed, predetermined amounts that vary according to patient need, regardless of providers' actual costs.

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studying HCFA's and the states' efforts to implement the Children's Health Insurance Program and will report on the results later this year.

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**HCFA's Handling of  
Ongoing Responsibilities  
for Financial Management  
and Routine Oversight  
Raises Serious Concerns**

Over the last several years, HCFA has been lax in managing critical ongoing program responsibilities, such as financial management—particularly by Medicare claims administration contractors—and oversight of nursing home compliance. For example, our work on high-risk programs such as Medicare highlighted the need for major federal financial management reforms, which the Congress initially enacted in the 1990 Chief Financial Officers Act and later expanded in the 1994 Government Management Reform Act. Under this legislation, the 24 major departments and agencies such as HCFA must now produce annual financial statements subject to independent audit, beginning with those for fiscal year 1996.

Since 1996, in conjunction with its audit of HCFA's financial statements, the HHS Office of Inspector General (OIG) has estimated the error rate for improper payments made by Medicare claims administration contractors. For fiscal year 1998, the OIG estimated that about 7 percent of Medicare fee-for-service payments for claims—\$12.6 billion—did not comply with Medicare laws and regulations. This represents an improvement over fiscal year 1997, when the OIG estimated that Medicare contractors made \$20.3 billion in improper payments—about 11 percent of all claims. However, the difference from 1997 to 1998 was almost entirely attributable to better documentation provided to the auditors, rather than to a substantive reduction in improper payments in categories such as “lack of medical necessity,” “incorrect coding,” and “noncovered services.”

HCFA has made progress in strengthening its financial oversight. Nevertheless, serious weaknesses remain for both Medicare and Medicaid. Many of the financial weaknesses in Medicare relate to its oversight of Medicare claims administration contractors, which process over \$700 million in Medicare fee-for-service claims each working day. In its audit of HCFA's 1997 financial statements, HHS' OIG found material weaknesses in managerial control over contractor operations, and, as a result, HCFA may not be collecting millions of dollars in overpayments from providers. The fiscal year 1997 audit identified one contractor transitioning out of the program that reported transferring \$266 million in accounts receivable to other contractors, but neither HCFA nor the auditors could determine whether these receivables had been transferred onto the new contractors' books. HCFA depends on contractors' financial reports to provide information for its financial statement because HCFA lacks an

integrated accounting system that can capture financial information at the contractor level. Moreover, the OIG found indications that HCFA's central and regional office oversight of operational and financial management controls was inadequate to ensure that contractor-provided financial information was consistent and accurate.

Similarly, the OIG found that security for contractor and HCFA information systems was inadequate, imperiling the confidentiality of Medicare beneficiary personal and medical data. While HCFA had corrected some weaknesses found during the audit for fiscal year 1996, it was still possible for an unauthorized user to gain access to HCFA's database and modify sensitive beneficiary files. HCFA has recognized the need to protect the security of its information systems and, starting in 1997, began revising security policy and guidance, and implementing corrective action plans. Because of the need to focus on Y2K modifications, however, HCFA probably will not address many of these weaknesses in the near term.

Medicaid financial management also is in need of reform. The OIG's 1997 audit revealed that HCFA had limited information on the federal portion of Medicaid accounts receivable and payable. In fiscal year 1997, HCFA relied on survey information from the states to estimate the amounts to record in the financial statements, and because the survey data were so limited, the OIG could not verify their accuracy. In addition, the audit noted that HCFA regional offices were not providing sufficient oversight of states' Medicaid claims processing and reporting, including states' efforts to deter fraud and abuse and collect overpayments.

HCFA's oversight of the quality of care Medicare and Medicaid beneficiaries receive also needs improvement. HCFA is responsible for defining requirements for certain providers, such as nursing homes and home health agencies, to participate in the Medicare and Medicaid programs and certify that their enforcement is adequate to protect the health and safety of Medicare and Medicaid beneficiaries. HCFA contracts with state agencies to review nursing homes and home health agencies for their adherence to these federal requirements. Our work has shown that HCFA's policies and oversight have been insufficient to ensure quality of care for nursing home residents or home health patients, and serious problems have resulted. One in nine nursing homes in the country were cited in both of the last two inspections for harming residents or putting residents' health and safety in immediate jeopardy—but such homes often faced no federal sanctions. In response, HCFA began taking actions to improve state inspection practices, revise state oversight activities, and strengthen enforcement for nursing

homes. HCFA has also added requirements that home health agencies demonstrate experience and expertise in home care by serving a minimum number of patients before initially certifying them as Medicare providers. However, these steps may not go far enough to protect vulnerable beneficiaries. We are now reviewing HCFA's oversight of state nursing home complaint investigations and inspections and will report to the Congress on these issues this year.

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## **HCFA Has Made Changes to Enhance Its Management Capacity, but Problems Persist**

Because its mission has been rapidly growing and changing, HCFA officials have worked hard to strengthen the agency's management capabilities. Despite these efforts, problems remain that hamper effective agency operations. While HCFA has developed a new focus on planning, including publishing a strategic plan, it does not require units to develop detailed plans to carry out day-to-day operations. The agency has completed its reorganization, but the resulting structure has contributed to various communication and coordination problems. Last year, HCFA lacked sufficient trained staff with the skills to effectively implement its top priorities. It hired more staff with needed skills in 1998, but it has not completed a long-term strategic approach to meet its future human resource needs. HCFA staff and managers are also concerned that its performance and award systems are not well linked to accomplishing its mission and that many managers are overburdened and lack managerial skills. These types of problems are found in other agencies, but HCFA still must be diligent in addressing them. The President's budget for fiscal year 2000 proposes a reform initiative for HCFA that is designed to increase its flexibility in the human resources area and to increase the agency's accountability.

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## **Tactical Planning Is Limited**

In December 1998, HCFA published its strategic plan, which focused on the organization as a whole and communicated the agency's vision, mission, and broad approaches to realizing that vision. This plan was developed to help HHS respond to requirements in the Government Performance and Results Act of 1993. In its strategic plan, HCFA clearly states that serving beneficiaries is its primary mission and, in doing so, the agency must be a prudent purchaser of health care. In addition to its overarching strategic plan, HCFA has also produced draft strategic plans for such significant areas as information technology and program integrity.

Strategic plans are an important first step; to be useful, however, they must be implemented. Tactical plans, which identify specific, measurable,

desired outcomes; time frames; and assignments of responsibilities for task completion, are critical. Last year, we reported that HCFA was not planning its activities on a tactical level. Although tactical planning has been used in some specific instances during the past year, such as to help track implementation of BBA requirements, HCFA has still not institutionalized this level of planning in its day-to-day operations.

In our interviews and focus groups, a pervasive theme was the need to work in a crisis mode, made worse by a lack of planning. For example, a staff member stated that she was being pulled from one “hot project” to another—which caused her to lose efficiency because she barely managed to master one subject before she was tasked with another. A manager told us that since the reorganization, little planning has taken place in his division, making even simple tasks harder. He said, as an example, that the divisions did not know how much travel money was available until the middle of the fiscal year and that routine trips had to be written up as emergencies to get approval. We heard similar concerns from managers and staff working on data systems and coverage policy.

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## **Reorganization Has Created Coordination Problems**

HCFA’s July 1997 reorganization established a totally new structure designed to better focus the agency as a “beneficiary-centered purchaser” of health care. The reorganization created new centers that were intended to respond directly to HCFA’s customers—the Center for Beneficiary Services, the Center for Health Plans and Providers, and the Center for Medicaid and State Operations—and to provide additional resources to Medicare’s growing managed care program.

In our January 1998 testimony, we noted that the agency’s staff had not yet moved to the actual location of their new organizational units, which tended to exacerbate problems with internal communication and coordination. Almost a year after the reorganization, between June and August 1998, HCFA completed the physical relocations, placing staff within their new organizational units. Relocation was a major undertaking because HCFA had made dramatic shifts of groups and people. An estimated 80 percent of HCFA central office staff, along with their computers, files, and shared office equipment, were relocated during the move. Managers told us that the physical move was implemented well, minimized work disruptions, and enhanced HCFA’s operational efficiencies.

The 1997 reorganization set out to eliminate HCFA’s “stovepipes” by placing policy and operations staff together in specific customer-focused

centers to enable them to work more closely together. We found that HCFA is still in the process of learning how to make its new organization work. Several managers said that they believe the quality of decision-making will be enhanced because input from many individuals and groups is required. But other managers and staff reported substantial internal and external communication problems as a result of the reorganization. For example, they said that the organization's decision-making process has become slow and cumbersome because it is more difficult to identify the key decisionmakers and find meeting times that can fit their busy schedules. We also were told that even identifying appropriate points of contact is sometimes difficult because new organizational titles are confusing. Finally, some managers and staff were concerned that when accountability for issues was shared by more than one center or office, tasks could "fall through the cracks" unless responsibilities were more clearly defined. Agency officials recognize that coordination is a problem and that there is sometimes a lack of accountability for decision-making. In response, they indicated that they are establishing teams on priority projects where key participants are identified and accountability for project completion is placed on one person.

HCFA's reorganization and emerging role as a health care purchaser and beneficiary advocate have also led to changes in the way HCFA communicates with those outside the agency. Some changes, such as those brought on by the Medicare+Choice program and the availability of Medicare and Medicaid information on the Internet, have increased interaction with providers, provider groups, and beneficiaries, according to several HCFA employees. Some staff we spoke with expressed concern about this increased workload and their inability to readily refer people to appropriate HCFA entities because the new organizational lines of responsibility are still unclear. Also, we found that although the Internet means that HCFA is "open 24 hours a day" and can communicate differently through this new medium, neither senior staff nor agency plans have fully addressed the impact of the Internet on HCFA's workload and how managers might need to reallocate responsibilities.

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**Maintaining Experienced  
and Appropriate Staff Will  
Continue to Be a  
Long-Term Need**

Last year, we reported that HCFA lacked sufficient staff with needed skills to effectively implement top-priority tasks. Today, managers are somewhat less concerned about staffing shortages because, during the year, HCFA hired more than 400 new employees—a net gain of more than 250 after accounting for attrition. Of the new staff, a little over one-half were hired as GS-7s through GS-12s and about one-third were health insurance



specialists. Senior agency officials told us that the new staff, with skills in areas such as managed care, private insurance, and market research, should help HCFA meet its new and growing responsibilities.

We believe that HCFA's focus on attracting new employees needs to be long term and continuous because it will continue to lose staff whose expertise must be replaced or supplemented. Over the next 5 years, almost a quarter of HCFA's staff—who make up a large part of the agency's management and technical expertise—will be eligible to retire. In addition, managers say HCFA will need staff with “real world” expertise in private industry, including those who know how to purchase care competitively. While HCFA has not fully assessed its long-term human resource needs, senior officials told us that the agency is taking initial steps toward developing a long-term plan for investing in its human resources. HCFA currently has a draft human resources plan that covers the years 1999 through 2003.

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**Performance System,  
Awards Program, and  
Flexible Work Hours Affect  
Agency Productivity**

HCFA managers and staff discussed a variety of factors that hamper agency operations and limit effective management. Although we believe that HCFA is not unique in experiencing these problems, mitigating them could improve agency performance. These include a pass/fail performance rating system where virtually all staff pass, an awards program that does not necessarily reward superior performance, and flexible work schedules and locations that limit staff availability. Participants in our focus groups believed that HCFA's performance appraisal system for nonexecutive staff does not allow managers to meaningfully assess and report on staff performance because virtually everyone receives a passing grade. Staff believed that the pass/fail system is demoralizing to hard workers because no adverse action is taken for unsatisfactory performance. Similarly, according to managers and staff, the performance appraisal system does not give staff a sense of satisfaction when they perform well because it fails to recognize outstanding efforts. Some cited the prior performance system as preferable because exceptional performers could benefit by receiving more rapid pay increases.

The Administrator found that the performance appraisal system for executives was also not useful in holding managers accountable and made changes this year to better differentiate senior managers' performance. The executive appraisal system has changed to a system with five levels of performance. Each executive manager has a performance agreement that is linked to performance goals for his or her set of responsibilities.

Many managers and staff members also told us that the current awards program is not working. Although the program is intended to motivate staff, the opinions we gathered suggest that it may have just the opposite effect. Each unit establishes its own panel that makes award decisions and controls award amounts. Panels consist of an equal number of union-appointed and management-appointed representatives. Each panel sets its own criteria for making awards and determining the portion of its awards budget to give to managers for “on-the-spot” awards, which are awarded directly to staff for performance on specific projects throughout the year. Managers told us that they would like to be able to distinguish among the accomplishments of staff members and reward them accordingly, but both managers and staff perceive the awards process as lacking equity and integrity. Any staff member can nominate another for an award, and we were told that staff members sometimes nominate themselves and friends nominate each other. Managers also told us that sometimes almost all nominees in a unit receive awards because panels find it difficult to distinguish among nominees’ performance. One manager who served as a panel member said that during the last fiscal year, about 250 employees were nominated for an award in his center—about two-thirds of all that center’s employees. He said that only five of the nominees did not get an award. Last fiscal year, panels awarded about \$678,000 to about 2,200 employees in grades 1 through 15—an average of about \$300 per awardee. Managers also directly awarded about \$213,000 through on-the-spot awards that can range from \$50 to \$250.

While staff were highly critical of the performance appraisal and awards processes, they approved of the flexibility to set their own work hours and work locations. HCFA’s personnel rules provide for flextime—in which employees may arrive at work at different times each day within core periods or work longer hours in a day and earn time off—and flexiplace—which allows employees to work at alternative locations. Under these rules, however, staff who work in the office only 4 days a week may be off when their managers need them to be in the office. Managers also told us that more time can be taken up with administrative matters as a result of more flexible work arrangements. They said that managing staff is more complicated, noting that planning the work, managing resources, and scheduling meetings is difficult, for instance, when all of the staff are only required to be in the office during a core period from Tuesday through Thursday—3 days a week. Employees need special approval to begin flexiplace, and a senior manager told us that they are now only approving about half of such applications.

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**Managers and Staff  
Express Concerns About  
Management Capacity and  
Training**

Some managers and staff discussed their concerns about supervisors' span of control and the lack of adequate training. They said that they believe some managers are responsible for supervising too many employees and do not have enough time to work with people who could benefit from on-the-job training. They also stated that some managers are not skilled at managing people, which they attribute largely to HCFA's tradition of promoting staff with excellent technical skills to the managerial level, and not rewarding them for developing their staff. Some also cited the lack of training provided to managers to improve their supervisory skills.

Many managers and staff agreed that HCFA does not provide enough training opportunities to help them do their work. We were told that new staff get little orientation to the agency's organization, programs, goals, and mission. Focus group participants added that limited training and travel funds prevented them from attending seminars and receiving training. Each HCFA staff member received an average of 8 hours of training last year. New staff, who generally were hired within the last year, averaged even fewer hours.

HCFA's senior management has identified management and other training as an area where HCFA must improve. The agency is developing a "model management initiative," which focuses on matching a manager's competencies with the specific skills that a manager needs for a given position. If approved by the Administrator, this model will be tested in the Office of the Chief of Operations. Then, if the initiative proves effective, it will be implemented in other parts of HCFA. HCFA is identifying better approaches to providing technical training and has doubled its training budget for next year—from about \$800,000 in fiscal year 1998 to about \$1.6 million in 1999.

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**HCFA Has New Proposals  
to Strengthen Management**

To strengthen HCFA's ability to meet growing responsibilities, the President's fiscal year 2000 budget proposes several reform initiatives. The budget seeks more personnel and pay flexibility to allow HCFA to recruit high-level staff with specific, needed skills, such as physicians and executives with managed care plan operational experience. Coupled with such flexibility, HCFA is seeking authority to selectively offer buy-outs to some staff members. In addition, HCFA is seeking new authority that would allow it to contract competitively for its Medicare claims administration contractors. To improve agency performance, HCFA is proposing to add an advisory board of corporate executives and management experts for advice on improving its business practices. Finally, HCFA wants to increase

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its accountability to the Congress by providing biannual reports on its progress.

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## Conclusions

As HCFA moves into the 21<sup>st</sup> century, its challenges will continue to become more numerous and complex. Once it has finished preparing for Y2K, HCFA must face tasks it has had to put aside or has not fully addressed. Several immediate challenges lie ahead. HCFA must finish and then refine program changes to fully realize the benefits expected from the BBA. It also needs to renovate antiquated, and streamline redundant, computer systems. Furthermore, it needs to strengthen its financial management and efforts to preserve program integrity.

Added to these responsibilities will be potential additional challenges associated with any restructuring of Medicare that follows the deliberations of the Bipartisan Commission on the Future of Medicare. Even if no major changes are introduced, HCFA's continuing challenges are taxing—strong leadership and management will be required to meet them. More effective planning, new staff with needed skills, and better accountability could help HCFA address these challenges and better ensure quality health care for the elderly, poor, and disabled. A true measure of HCFA's success will be its ability to maintain current momentum as it enters the 21<sup>st</sup> century.

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Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

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# Related GAO Products

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Major Management Challenges and Program Risks: Department of Health and Human Services ([GAO/OCG-99-7](#), Jan. 1999).

High-Risk Series: An Update ([GAO/HR-99-1](#), Jan. 1999).

Medicare Computer Systems: Year 2000 Challenges Put Benefits and Services in Jeopardy ([GAO/AIMD-98-284](#), Sept. 28, 1998).

California Nursing Homes: Care Problems Persist Despite Federal and State Oversight ([GAO/HEHS-98-202](#), July 27, 1998).

Balanced Budget Act: Implementation of Key Medicare Mandates Must Evolve to Fulfill Congressional Objectives ([GAO/T-HEHS-98-214](#), July 16, 1998).

Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities ([GAO/HEHS-98-160](#), June 1, 1998).

Medicare Managed Care: Information Standards Would Help Beneficiaries Make More Informed Health Plan Choices ([GAO/T-HEHS-98-162](#), May 6, 1998).

Financial Audit: 1997 Consolidated Financial Statements of the United States Government ([GAO/AIMD-98-127](#), Mar. 31, 1998).

Medicaid: Demographics of Nonenrolled Children Suggest State Outreach Strategies ([GAO/HEHS-98-93](#), Mar. 20, 1998).

Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century ([GAO/T-HEHS-98-85](#), Jan. 29, 1998).

Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies ([GAO/HEHS-98-29](#), Dec. 16, 1997).

Medicare: Effective Implementation of New Legislation Is Key to Reducing Fraud and Abuse ([GAO/HEHS-98-59R](#), Dec. 3, 1997).

Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation ([GAO/T-HEHS-98-41](#), Oct. 29, 1997).

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